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Section 1: Personal Details *(If the question is irrelevant or information is not known, please write Not Applicable or N / A)*

First Name:	Surname:		
Current Address:			
Suburb:	Postcode:		
Person Completing This Form <i>(if other than Person Requiring Support)</i>	Relationship to person:		
	Daytime phone:		Mobile phone:
	Email:		
DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Preferred Spoken Language:	Cultural affiliation / Koori?		
Interpreter Required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language:		
Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Guardian:		
	Contact number:		
Legal Administrator: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Administrator:		
	Contact number:		
Medicare number:	Pension number:		
	Type of Pension:		
Taxi Card: <input type="checkbox"/> Yes <input type="checkbox"/> No	Companion Card: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Contact Details	Name:		
	Relationship:		
	Contact number:		
General Practitioner Details	Name:		
	Address:		
	Contact Number:		

Section 2: Medical History *(tick preferred box)*

Current issues:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Dental | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Seizure/fits/epilepsy | | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> ABI (trauma, drug use, infection, tumor, hypoxia) |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skeletal injuries | |
| <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: |

List current medications and doses:

Dosette Box?

Yes

No

General Hospital Admissions and frequency:

Section 3: Psychosocial History:

Marital Status (tick one):

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Never married | <input type="checkbox"/> Married/de-facto | <input type="checkbox"/> separated |
| <input type="checkbox"/> Married | <input type="checkbox"/> divorced | <input type="checkbox"/> re-married |

Family Relationship/Children
e.g. child care responsibilities, involvement of Child Protective Services?

Finances/Employment *(e.g. Major source of income, employment history):*

- | | |
|---|--|
| <input type="checkbox"/> Aged Pension | <input type="checkbox"/> Unemployment – related benefits |
| <input type="checkbox"/> Veterans' Affairs pension | <input type="checkbox"/> Other government pension or benefit |
| <input type="checkbox"/> Disability Support pension | <input type="checkbox"/> No government pension or benefit |
| <input type="checkbox"/> Carer Payment (pension) | |

Education/Training *(e.g. highest level of education achieved, literacy skills):*

Recreational Interests *(e.g. hobbies, sports, music, gym, reading, fishing):*

Previous Accommodation History: *(e.g. stable, supportive, crisis accommodation, Homeless or at risk of becoming homeless, substance use in household)*

Section 4 Support Network:

Informal Support Network:

Formal Support Network:

- | | | |
|---|--|--|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Community nursing services | <input type="checkbox"/> Palliative carer facility/hospice |
| <input type="checkbox"/> Specialist aged or disability assess. team/serv. (eg ACAT) | <input type="checkbox"/> Hospital (public) | <input type="checkbox"/> Aboriginal health services |
| <input type="checkbox"/> Comprehensive HACC assessment authority | <input type="checkbox"/> Psychiatric health services | <input type="checkbox"/> Centrelink services |

Other current relevant services and professional supports:

Section 5: Alcohol and other Drug History (tick preferred box)

(If the question is irrelevant or information is not known, write Not Applicable or N/A)

Drugs of choice:

History of other Drugs used:

 Yes No

Have you ever experienced Withdrawal Symptoms?

 Yes No

Depressants:

- Alcohol
- Minor tranquillisers/benzodiazepines e.g. (Rohypnol, Valium, Serepax, Mogadon, Normison, Euhypnos)
- Heroin
- Cannabis
- Solvents and inhalants (petrol, glue, chrome paint, lighter fluid)

Stimulants:

- Amphetamines
- Cocaine
- Nicotine
- Caffeine

Hallucinogens:

- LSD (acid)
- Ecstasy (MDMA)
- PCP (angel dust)
- Magic
- Mushrooms

Have you ever overdosed?

 Yes No

When was the last time?

Previous Alcohol and Drug Interventions

 Residential Rehab (therapeutic community) AOD counseling Self-help groups (Alcoholics Anonymous) Detoxification Services:

(e.g. Residential, Medical, Community Based-home)

 Substitution pharmacotherapy

(Methadone, Naltrexone, Subtext, Buprenorphine)

Notes:

Section 6: Mental Health History (tick preferred box)

(If the question is irrelevant or information is not known, write Not Applicable or N/A)

Please list previous psychiatric history/Diagnosis/Assessments:

Abnormal thought process:

- Confusion
- Disorientation

Mood:

- Elevated
- Depressed
- Flat

Assessment of suicide or self harm risk:

- Sense of hopelessness/worthlessness?
- Ideation of killing/harming yourself?
- Intent to kill/harm yourself?
- Plan (How would you do it?)
- Lethality (Is the method likely to be lethal?)
- Accessibility?
- Previous attempts?

Currently receiving treatment?

 Yes No

Treatment receiving:

Name:

Telephone:

Is a full psychiatric assessment required?

 Yes No

Section 7: Accommodation Support Needs

7.1 Overview of person

- Describe yourself in terms of your strengths interests and goals.
- Include current circumstances and living situation.

7.2 Personality/Compatibility

- Describe your personality, for example, sociable, strong-willed, risk-taker, disruptive, etc.
- Do you have any personality traits or behaviour that may cause disruption to others,?
- How would you feel if others demonstrated disruptive behaviours?

7.3 Communication

- How do you interact with others, including staff and peers?
- What are your receptive communication skills and do you utilise any communication aids.

7.4. Vocational Status

- Are you currently employed? Full or part time?
- Do you currently attend a set activity or work during the day? Full or part time?

Section 7.5 Individual Supports required to live in Unit

Goal	Supports required	Frequency and Duration	Formal or informal supports currently providing support
<i>Example: To remain independent in my living arrangements</i>	<i>Help with meal preparation</i>	<i>Two x two hour sessions per week x 52 weeks</i>	

Section 8 Consent (The person requiring support or their designated representative must confirm the details in this Request)

Name in Full

Signature

Date

OFFICE USE

Client Summary

Summary of client, covering essential issues (e.g. general presenting problem, relevant A & D, medical and psychosocial history, including provisional diagnosis, clients motivation, barriers to treatment)

Main issues identified by worker (to assist with formulation of Individual Care Plan):
Identify on-going issues:

Recommended *arbias* Accommodation option

Accommodation Type	Rational	Client Consent Yes / No	Date

Assessment of Formal Supports Required to Facilitate Accommodation in Recommended Accommodation Type

Name Date

Signature Position